Printed: 10/22/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM			A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175506		B. WING		10/22/2014		
NAME OF PR	OVIDER OR SUPPLIER OME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 W CRANE ST NORTON, KS 67654					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE C	(X5) COMPLETION DATE	
F 000	F 000 INITIAL COMMENTS The following citations represent the findings Health Resurvey and Complaint Investigation #75516.			F 000				
	483.10(b)(11) NOTIF (INJURY/DECLINE/F			F 157				
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.		tive s an in sician dent's , a cial					
			ative					
			ent's					
	This Requirement is	not met as evidenced b	oy:					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2	22/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ANDBE H	OME, INC			CRANE ST N, KS 6765	4			
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F 157	sample included 14 re observation, interview facility failed to notify manner, for 1 sample accident, experienced fractured left ankle. (# Of the 14 sampled resunnecessary drug use record review and obserport elevated blood for 1 of 5 sampled resundings included: - The (POS) Physicia #33, dated 9/18/14, in (CVA) Cerebrovasculasided hemiplegia (parbody). The annual (MDS) Mi assessment, dated 7/was cognitively intact Interview for Mental Sextensive assistance and transfers, and was locomotion. The MDS balance during surfact unsteady and he/she balance, the resident of Motion in 1 upper a MDS indicated the resmobility, had no falls a received (OT) Occuparestorative range of mof the look back perior	sus of 64 residents. The esidents. Based on and record review the the physician in a timel desident who had and swelling and pain, and fassed on interview, servation the facility fail pressures to the physicial pressures to the pressure to the pressure to the pressure to the previous MDS attional Therapy and notion exercises over 4	y d a ed for ed to cian dent h left e sident ired ility s as ange he air for s days	F 157				

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	NAME OF PROVIDER OR SUPPLIER ANDBE HOME, INC		201 W C	RESS, CITY, STA CRANE ST N, KS 6765				
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F 157	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		th left he and right ed an of sident es. I to ay rs. use en the re the ess uring ted nd did ed at s/her nt foot te is/her r. The and a	F 157				

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			NORTO	N, KS 6765	4		
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F 157	Continued From page 3			F 157			
	swelling, redness or b	oruising at that time. Th	e				
		okay and independent	ly				
	propelled his/her whe	elchair down the hall.					
	The 8/11/14 at 3·30 Δ	M, nurse's note indicat	ed				
		ned of pain in his/her lef					
		e/she bumped it on his/					
		. The note indicated the					
		eft ankle was swollen a					
] -	the staff barely touche ted the nurse administe					
		medication), as needed					
	T	staff applied an ice pack					
		le. Review of the medic	cal				
		ocumentation the staff					
	reassessed the reside	ent's ankie untii irs later. Further review	of				
		vealed no documentati	I				
		hysician regarding the					
	incident and the resid	lent's increased pain or					
	swollen left ankle.						
	The 9/11/14 at 4:00 E	PM, the physician's tele	ohono				
		iff to transport the resid					
		ay of his/her left ankle.					
	(more than 23 hours	after the accident and r	nore				
		ne staff noted the reside	ent's				
	left ankle was painful	and swollen)					
	The 8/11/14 at 8:35 P	PM, nurse's note indicat	ed				
		e pain in his/her left an	I				
	had increased despite	e the ice packs the staf	f				
	applied and he/she received Tylenol (pain relief						
	medication), as needed. Review of the medical		I				
	record revealed the resident received scheduled Lortab at bedtime. The note indicated the nurse						
		family who agreed the					
		ld be x-rayed and the s					
		ent to the hospital at 4:3	I				
	PM. The note stated to	the staff continued to a	pply				

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F 157	Continued From pag	e 4		F 157			
	ice packs, as needed, and Lortab as scheduled.						
	The 8/13/14 facility report stated the staff pushed the resident, in his/her wheelchair, into the hallway while the resident held up his/her flaccid (weak) left foot, with his/her right foot. The report indicated the resident's left foot slipped off his/her right foot, was caught on the carpet and bent under the wheelchair or bumped the wheelchair wheel.						
	On 10/14/14 at 10:50 AM, observation revealed the resident was in the beauty shop, in his/her electric wheelchair, his/her feet on a single full foot platform, with shoes on.						
	On 10/14/14 at 4:39 PM, observation revealed (CNA) Certified Nurse Aide K and L used a sit to stand lift to transfer the resident from his/her recliner to the toilet. Observation during the transfer revealed the resident's left arm hung down, limp and he/she used his/her right arm to hold on to the lift with both feet positioned forward on the lift platform. After the CNAs assisted the resident with toileting needs, they transferred the resident to his/her electric wheelchair and the resident independently propelled the wheelchair down the hall, at a slow to moderate speed, with both feet centered on the foot platform.						
	On 10/14/14 at 4:00 PM, (CMA) Certified Medication Aide M stated the resident always had both foot pedals on his/her wheelchair at all times, when being pushed by the staff. He/She stated the resident had left sided weakness, but was able to stand for transfers in the sit to stand lift.						
		AM, Administrative Nursas able to report what	se F				

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F 157	Continued From page	<u> </u>		F 157					
1 137		e 5 he hurt his/her ankle. T	ho	1 137					
		herapy evaluation, and	I						
		ived physical therapy, s							
		the care plan. He/She							
	_	appened on the evening	I						
		not complain of pain ur							
		physician and family v	I						
	notified the next day.	Administrative Nurse F	:						
		nurse had not documer	nted						
	any assessment and								
	documentation the staff notified the physician								
		at 4:00 PM, on the sec	I						
		Nurse F stated the day	I						
		llowed up and assessed received a report that the	I						
		needed pain medication	I						
		night for a painful, swoll	I						
		e physician. Administra	I						
		lay shift nurse should h							
		of the accident and the	I						
		ollen ankle. He/she stat	I						
	the facility's fall policy								
	accidents.								
		PM, Physician G stated							
		the staff to notify him/h							
		the resident, especially	I						
		and the staff should rea							
		nning of each shift Phys							
		d expect the staff to us	I						
	the resident in any wh	ecautions when transpo	rung						
	the resident in any Wi	icciciaii.							
	The facility's 2007 fall policy directed the staff to		ff to						
	notify the resident's family and physician of								
	falls/accidents and up								
		- r - ·							
	The facility's 3/15/13	policy for notification of	the						
		e staff to notify the phys							
	by phone, when the re	esident had pain or							

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F 157	Continued From page 6			F 157				
	deformity from a fall of							
	The facility failed to notify Resident #33's physician, in a timely manner, after he/she had an accident, resulting in a swollen, painful ankle, and a resulting fracture. - Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 9/29/14, indicated the resident scored 15 on the (BIMS) Brief Interview for Mental Status, which indicated intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities for Daily Living, ambulated with a walker, and was continent of bowel and bladder. The MDS indicated the resident received 7 days of an antidepressant medication.							
	The 4/30/14 (CAAs) Care Area Assessment summary for psychotropic drug use did not indicate any instructions for the monitoring and reporting of a resident's elevated blood pressure. The CAAs indicated the resident was a high risk for falls as he/she had frequent falls prior to admission to the facility and the resident's physician readjusted the resident's medications to prevent further falls prior to his/her admission. The 9/29/14 care plan indicated the staff were to administer the resident's medications as ordered per physician's orders and to assess and record effectiveness of the drug treatment. The 4/21/12 standing order for notifying the resident's physician for elevated blood pressures stated when the resident's (SBP) systolic blood pressure (top number) was above 170, or diastolic blood pressure (bottom number) was above 95, to recheck the resident's blood		and sure. risk					
			ered					
			ood					

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F 157	pressure in 15 minute readings to the resided. The 9/29/14 physicia 4/22/14) instructed the resident's blood present the systolic blood present to administer: 1) Coreg, (a high blood (mg) milligrams, twice 2) Cozaar (a high blood mg, twice a day. The 5/1/14 physician to administer Norvasch medication), 5 mg, two the resident had epis. The 9/18/14 physician to increase Norvasch medication), to 5 mg, continues on the Conference of the SBP to be report of the SBP, and structed to the stated Norvasch medication) was increased in the resident's blood positing 185/89, and structed to the stated Norvasch medication) was increased in the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident of the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident of the resident's blood positing 185/89, and structed Norvasch medication) was increased in the resident of the reside	es and then report the ent's physician. In's order, (initiated on the staff to obtain the sure twice a day and ressure was <100 and dinge. In's order instructed the od pressure medication at a day. It's order instructed the set of pressure medication at a day. It's order instructed the set, (a high blood pressure indicated odes of high blood pressure twice a day. The residuation at a day.	staff), 25 h), 50 staff re cated ssure. e staff ent ord climits ated 79/84, rses's	F 157				

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	•		NORTO	ON, KS 67654					
(X4) ID	SLIMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION (X5)			
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TAG	OR LSC ID	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRI	OPRIATE			
					DEFICIENCY)				
F 157	Continued From pag	e 8		F 157					
	The resident's medical record revealed the resident's following blood pressures outside the								
	standing order's for b	lood pressure notification	on:						
	10/14/14 at 9:20 AM								
	10/9/14 at 7:43 AM 1								
	10/8/14 at 7:25 AM 1								
	10/6/14 at 4:00 PM 1								
	10/5/14 at 1:05 PM 178/92								
	10/2/14 at 2:59 PM 179/88								
	10/2/14 at 7:08 AM 174/89 10/1/14 at 2:55 PM 172/83								
	10/1/14 at 2:55 FM 1								
	10/1/14 at 9:46 AM 1								
	9/29/14 at 3:16 PM 1								
	9/29/14 at 7:30 AM 1								
	9/26/14 at 10:53 AM								
	9/26/14 at 7:35 AM 1								
	9/25/14 at 2:59 PM 1	72/87							
	9/25/14 at 6:49 AM 1	86/81							
	9/24/14 at 7:57 AM 1	78/85							
	9/23/14 at 7:11 AM 1	74/84							
	9/21/14 at 7:17 AM 1	80/84							
	9/17/14 at 3:42 PM 1	72/84							
	9/16/14 at 9:45 AM 1	86/86							
	9/16/14 at 7:00 AM 2	03/87							
	9/14/14 at 3:52 PM 1								
	9/12/14 at 7:28 AM 1								
	9/11/13 at 6:50 AM 20								
	9/9/14 at 7:03 AM 17								
	9/8/14 at 6:38 AM 18								
	9/7/14 at 7:26 AM 172/77								
	9/6/14 at 7:40 AM 17:								
	9/5/14 at 9:07 AM 17:								
	9/4/14 at 4:07 PM 19								
	9/3/14- at 7:05 AM 18 9/2/14- at 7:17 AM 18								
	<i>31∠114-</i> at 1.11 AIVI 18	วงเอง							
	Further review of the	resident's medical reco	ord						

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F 157	revealed no staff follor the resident had eleval occasions, and no phresident's elevated blook on 10/14/14 at 11:03 the well groomed resihis/her room, reading On 10/16/14 at 7:25 Anurses or the medical blood pressures. On 10/16/14 at 8:45 Anurses take the resident's of 90-170/40-95 per sverified the resident houtside of the standing red in the vital sign resident houtside of the standing red in the vital sign resident's of 90-170/40-95 per sverified the resident houtside of the standing red in the vital sign resident houtside of the standing red in the vital sign resident houtside of the standing resident houtside of the standing resident houtside of the standing resident's blood pressures administering the resident's blood pressures administering the resident's blood pressures administering the resident's houtside of the staff had be resident's nurse's not verified the staff had be physician regarding the control of 10/16/14 at 10:30 he/she expected the staff had be physician regarding the control of 10/16/14 at 10:30 he/she expected the staff had be physician regarding the control of 10/16/14 at 10:30 he/she expected the staff had staff had be physician regarding the control of 10/16/14 at 10:30 he/she expected the staff had staff ha	ow up documentation af ated blood pressures, on a sysician notification of the lood pressures. AM, observation reveal ident, resting in a recling e-mails on a touch pace. AM, Nurse Aide D state tion aides take the resident's blood pressure parameters belood pressure parameters and several blood pressure produced in the entity of the resident error. AM, Administrative Nurse is to report, to the resident error of	en 33 ne alled er, in d. d the dent's eters sures, ed in se F nt's order s/her the s if it ne se F t's sures. d d	F 157			

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F 157 F 323 SS=G	He/she stated it as di morbidity (the incider (the state of being su in the nursing homes one of them. The facility failed to reblood pressures, to he/she received multimedications. 483.25(h) FREE OF AHAZARDS/SUPERVI	fficult to change the nce of disease) or mortal bject to death) of reside, but blood pressure we eport Resident # 8's eleis/her physician, while iple blood pressure ACCIDENT ISION/DEVICES	ents ere	F 157			
	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.						
	This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 14 residents of which 4 were reviewed for accidents. Based on observation, interview and record review the facility failed to provide care and services to prevent injuries during transport with a wheelchair, which result in a fracture, for 1 of 4 residents reviewed for accidents. (#33) Based on observation, record review and interview the facility failed to adequately monito the water temperature on 1 of 4 halls to ensure the hot water temperature was within safe, acceptable ranges for the residents residing on the hall.		ne n				
	are nan.						

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F 323	Continued From page 11			F 323			
	Findings included: - The (POS) Physician Order Sheet for Resident #33, dated 9/18/14, indicated diagnoses of a (CVA) Cerebrovascular Accident (stroke) with left sided hemiplegia (paralysis of one side of the body). The annual (MDS) Minimum Data Set assessment, dated 7/28/14, indicated the resident cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15, required extensive assistance of 2 staff with bed mobility and transfers, and was independent with locomotion. The MDS indicated the resident's balance during surface to surface transfer was unsteady and he/she required assistance to balance, the resident had impaired (ROM) Range of Motion in 1 upper and 1 lower extremity. The MDS indicated the resident used a wheelchair for mobility, had no falls since the previous MDS, received (OT) Occupational Therapy and restorative range of motion exercises over 4 days of the look back period. The 7/28/14 (CAA) Care Area Assessment for falls stated the resident had no falls this review period, was non-ambulatory and status post CVA with left sided hemiplegia. The summary indicated the staff used the sit to stand lift for all transfers and the resident was able to hold on with his/her right arm. The summary indicated the resident used an electric wheelchair for his/her primary mode of locomotion, and the staff encouraged the resident to wear nonskid footwear or socks at all times. The 7/28/14 care plan for falls indicated the resident used an electric wheelchair for		sident ev for re uring d on in				
			ew CVA r all on ed the				

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ANDBE H	OME, INC			RANE ST N, KS 6765	4		
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F 323	locomotion and direct stand lift with 1 staff a and 2 staff assistance. The care plan lacked of the manual wheelch electric wheelchair with plan lacked instruction resident's left leg (whand hemiplegia) was transport in the manual. The 8/1/14 at 12:41 Fithe resident's electric but not completely fix quit working. The not was unable to wheel not like to have help. The 8/10/14 at 4:34 Fithe 4:00 PM, the staff purmanual wheelchair, or resident positioned his hemiplegia) over his wheelchair foot pedal indicated the resident right foot and was be note indicated the resident stated it was propelled his/her wheelchair stated it was propelled his/her wheelchair yesterday noted the resident's lepainful to touch where area. The note indicated indicated the resident's lepainful to touch where area. The note indicated indicated the resident's lepainful to touch where area. The note indicated indicated the resident's lepainful to touch where area. The note indicated indicated the resident's lepainful to touch where area. The note indicated indicated the resident's lepainful to touch where area. The note indicated the resident's lepainful to touch where area. The note indicated the resident's lepainful to touch where area.	ted the staff to use a site assistance during the deat night for all transfer updates regarding the chair during periods who as not working. The carn for the staff to ensure ich had muscle weakned appropriately secure deal wheelchair. PM, nurse's note indicated wheelchair was workinged and would sometime further stated the resident amanual wheelchair and part of the resident, in his put into the hall while the is/her weak left foot, with no insigher right foot, with no	ay rs. use en the re e the ess uring ted ng, es ident and did ed at s/her e fected o is/her r. The and a nd no ne ely ted ft ft fher e staff and did ted the ered	F 323			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10.	/22/2014
NAME OF PR	OVIDER OR SUPPLIER OME, INC		201 W C	RESS, CITY, STA RANE ST N, KS 6765			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REOR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	the resident and the the resident's left and record revealed no dreassessed the reside approximately 11 late medical record revealed the physical and the resident's included and the resident's included and the resident's included and the resident's included and the state of the hospital for an x-(more than 23 hours than 12 hours after the state of the resident state of the resident state of the resident and he/she in medication), as need record revealed the resident's ankle shout transported the resident's resident's ankle shout transported the resident's notified the resident's notified the resident's ankle shout transported the resident's ankle shout transported the resident's notified the resident, in his/he hallway while the resident right foot, was caugh under the wheelchair wheel.	staff applied an ice packle. Review of the medic locumentation the staff lent's ankle until er. Further review of the aled no documentation to sician regarding the incipared pain or swollen. The pain of the staff to transport the resident ray of his/her left ankle. after the accident and rate the ice packs the staff eceived Tylenol (pain reflect. Review of the medices and the staff who agreed the note indicated the number of the staff continued to a did and Lortab as schedule eport stated the staff puer wheelchair, into the sident held up his/her weident held up his/her weide	cal the dent left phone ent to more ent 's ted kle felief cal uled urse estaff 30 pply aled. shed eak is/her it hair	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10.	/22/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ANDBE H	OME, INC			RANE ST N, KS 6765	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGION OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	the resident was in the electric wheelchair, h foot platform, with short on 10/14/14 at 4:39 f Nurse Aide K and L utransfer the resident toilet. Observation duthe resident's left arm he/she used his/her rwith both feet position platform. After the CN with toileting needs, to his/her electric whe independently propel hall, at a slow to mod centered on the foot platform at all time staff. He/She stated the weakness, but was a the sit to stand lift. On 10/16/14 at 8:44 of stated the resident with appened when he/s verified the staff had either before the accimanual wheelchair, opositioned the reside using the wheelchair, opositioned the reside using the wheelchair, appened on the even not complain of pain physician and family Administrative Nurse had not documented facility had no documented fac	ne beauty shop, in his/h is/her feet on a single foes on. PM, observation revealesed a sit to stand lift to from his/her recliner to aring the transfer reveales hung down, limp and ight arm to hold on to the hed forward on the lift NAs assisted the reside hey transferred the reselchair and the resider led the wheelchair dow erate speed, with both	ed the ed the ed the lift nt ident nt the feet ed the her by the ed s in se F le/she lan of the taff when ident did the lay. nurse ne ed the	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/22/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ANDBE H	OME, INC		201 W C	RANE ST			
			NORTO	N, KS 6765	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 323	Continued From pag	e 15		F 323			
	the day shift nurse sh	ninistrative Nurse F state nould have followed up	and				
		it after he/she received	I				
	•	nt received as needed acks during the night fo					
	Tel control of the co	e. Administrative Nurse					
		nurse should have notif					
		accident and painful, sw					
		the facility's fall policy v					
	also used for accidents. On 10/21/14 at 2:15 PM, Physician G stated						
	•	the staff to notify him/h					
	_	the resident, especially					
		and the staff should rea					
		nning of each shift Phys ld expect the staff to us					
		ecautions when transpo					
	the resident in any wh		Tung				
	The facility's 2007 fal	I policy directed the sta	ff to				
		amily and physician of					
	falls/accidents and up	odate the care plan.					
	The facility failed to tr	ansport this dependent	t				
	resident via wheelcha	air, in a safe manner, w	hich				
		of his/her left ankle/foo					
		8 AM, observation reve					
		ple resident bathrooms					
		s too hot for this survey					
	•	inder the faucet stream es were checked in the					
	following rooms:	ca were checked in the					
	East 2 - 138.0 degree	es					
	East 3 - 134.8 degree						
	East 5 - 138.7 degree						
	East 6 - 137.6 degree						
	East 8 - 134.6 degree						
	East 9 - 132.8 degree						
	Therapy room on eas	st hall - 133.8 degrees					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/22/2014	
ANDBE HOME, INC 201 V			201 W C	RANE ST N, KS 67654			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 323	On 10/14/14 at 8:46 A temperatures in the reported to the mainter staff turned off the hore. Review of the facility' Temperature Checklis documentation the stawater temperatures of following days: 09/12/14 09/19/14 09/26/14 10/02/14 10/09/14 On 10/14/14 at 8:46 A stated the maintenan water temperature we rooms and recorded froom number on the Temperature Checklis also stated there was had checked water tein the past month.	AM, the hot water esidents' bathrooms we enance department and it water to the east hall. It water to the east hall. It water to the east hall is Weekly Water est form revealed no aff had checked the hot on the east hall on the east hall on the east hall on the eekly in random resider the water temperature affacility's Weekly Water est form. Maintenance Stand documentation the emperatures on the east AM, Nurse Aide B state	A e hot and taff A staff t hall	F 323	DEFICIENCY)		
	the hot water temperature had been elevated in the residents' bathrooms on the east hall for at least a week. Nurse Aide B also stated he/she was not aware if the hot water temperature had been reported to the maintenance department. On 10/15/14 at 10:45 AM, Housekeeping Staff C stated the hot water temperature had been elevated on the east hall for several days and he/she had not reported the unsafe hot water temperature to the nursing or maintenance staff.						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
ANDILANO	CONNECTION		-IV.	A. BOILDING		GOWII EET	LD	
		175506		B. WING		10/2	2/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
ANDBE H	OME, INC			CRANE ST ON, KS 6765	4			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	On 10/15/14 at 11:02 stated the staff should temperature on each immediately if unsafe noted. Administrative direct care staff shoul water temperatures to maintenance staff. The facility failed to at temperature on 1 hall temperature was with	AM, Administrative State of check the hot water hall weekly and address water temperatures we Staff H also stated the direport elevated/unsate administration or the dequately monitor the vito ensure the hot water in safe, acceptable ran	ere fe hot water er ges.	F 323				
SS=D								

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10	/22/2014	
NAME OF PR	OVIDER OR SUPPLIER OME, INC		201 W C	ESS, CITY, STATE RANE ST N, KS 67654				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULANCE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	The facility had a cer sample included 14 reviewed for unneces interview, record revifacility failed to monit sampled residents. Treassess Resident # and monitor Resider order to prompt asses interventions to preventions to preventions included: Resident #8's quar Set assessment, data resident scored 15 of for Mental Status, who cognition. The MDS independent with mound Living, ambulated with continent of bowel are indicated the resident antidepressant medicated the resident antidepressant medicated any instructive reporting of a resider	a not met as evidenced it insus of 64 residents. The residents of which 5 were sarry drug use. Based of iew and observation the tor drug side effects for The facility failed monito 8's elevated blood present #7's bowel elimination is sament to determine neent or ease constipation the (BIMS) Brief Internich indicated intact indicated the resident wast (ADLs) Activities for the a walker, and was and bladder. The MDS at received 7 days of an cation. Care Area Assessment tropic drug use did not ons for the monitoring ant's elevated blood president in the sull and the monitoring ant's elevated blood president in the monitoring ant's elevated blood president in the sull and the monitoring ant's elevated blood president in the monitoring and the monitoring ant's elevated blood president in the monitoring and the monitoring	e e e e e e e e e e e e e e e e e e e	F 329				
	The CAAs indicated the resident was a high risk for falls as he/she had frequent falls prior to admission to the facility and the resident's physician readjusted the resident's medications to prevent further falls prior to his/her admission. The 9/29/14 care plan indicated the staff were to administer the resident's medications as ordered per physician's orders and to assess and record		ons to n. re to ered					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175506		B. WING		10/22/2014			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE				
ANDBE H	OME, INC			W CRANE ST					
			NORTO	N, KS 6765	4				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION			
F 329	Continued From pag	e 19		F 329					
	effectiveness of the d	Irug treatment.							
	resident's physician firstated when the resident's pressure (top number diastolic blood pressurabove 95, to recheck pressure in 15 minute readings to the resident's physician 4/22/14) instructed the resident's blood pressure in 15 minute readings to the resident's blood pressure in 15 minute readings to the resident's blood pressure in 15 minute readings to the resident's blood pressure in 15 minute resident's blood pressure resid	the resident's blood es and then report the ent's physician. n's order, (initiated on se staff to obtain the sure twice a day and ressure was <100 and di	port if						
	to administer: 1) Coreg, (a high blood (mg) milligrams, twice 2) Cozaar (a high blood mg, twice a day. The 5/1/14 physician to administer Norvasch medication), 5 mg, day The 7/14/14 physician the resident had epis	's order instructed the sc, (a high pressure aily. n's progress notes indicodes of high blood pres	o), 25 o), 50 otaff cated cated ssure.						
	The 9/18/14 physicians's order instructed the staff to increase Norvasc, to 5 mg, twice a day. The resident continues on the Coreg and the Cozaar. Further review of the resident's medical record did not indicate specific individualized upper limits of the SBP to be reported to the resident's physician.								

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/22/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
ANDBE H	OME, INC		201 W C	RANE ST			
			NORTO	N, KS 67654	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE JENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 329	Continued From pag	ie 20		F 329			
F 329	The 9/23/14 at 8:28 Athe resident's blood positting 185/89, and structure a day, due to the pressure. The resident's medicaresident's following botanding order's for botanding	AM, nurse's notes indicatoressures were: lying 17 anding 176/84. The nur (a high blood pressure eased on 9/18/14 to 5m re resident's elevated by all record revealed the lood pressures outside blood pressure notification 177/75 82/80 77/70 72/89 78/92 79/88 74/89 72/83 73/65 87/90 78/83 86/76 177/70 88/76 72/87 86/81 78/85 74/84 80/84 72/84 86/86 03/87	79/84, rses's ng, lood the	F 329			
	9/16/14 at 9:45 AM 186/86 9/16/14 at 7:00 AM 203/87 9/14/14 at 3:52 PM 181/59 9/12/14 at 7:28 AM 189/89 9/11/13 at 6:50 AM 200/80 9/9/14 at 7:03 AM 176/88 9/8/14 at 6:38 AM 181/85 9/7/14 at 7:26 AM 172/77						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/22/2014
	OVIDER OR SUPPLIER OME, INC		201 W C	ESS, CITY, STA RANE ST N, KS 67654	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 329	9/6/14 at 7:40 AM 17 9/5/14 at 9:07 AM 17 9/4/14 at 4:07 PM 19 9/3/14- at 7:05 AM 18 9/2/14- at 7:17 AM 18 Further review of the revealed no staff folio the resident had elev occasions, and no phresident's elevated blood president's elevated blood pressures. On 10/16/14 at 11:03 the well groomed reshis/her room, reading On 10/16/14 at 7:25 nurses or the medical blood pressures. On 10/16/14 at 8:45 nurses take the resid verified the resident's of 90-170/40-95 per sident's of	3/77 2/83 0/76 38/90 33/83 resident's medical recomble up documentation aformation and ated blood pressures, on a signification of the coordinate of the co	eters eters eters sures, ed in se F nt's ding by nt the er F	F 329		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2	22/2014	
NAME OF PROVIDER OR SUPPLIER ANDBE HOME, INC			201 W	CRANE ST DN, KS 6765		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	verified the resident h pressures with no doo pressure being repea notification. On 10/16/14 at 10:30 he/she expected the resident's blood p He/she stated it was of morbidity (the inciden (the state of being sul	es. Administrative Nurs ad several elevated blocumentation of the blooted or the physician AM, Physician G statemers to notify him/her ressures were elevated difficult to change the ce of disease) or mortablect to death) of reside	d d if d. d.	F 329				
	in the nursing homes, but blood pressure were one of them. The facility failed to adequately monitor and reaccess Resident # 8, who received blood pressure medication and had numerous elevated blood pressures. - Resident #7's quarterly (MDS) Minimum Data Set assessment, dated 9/2/14, indicated a (BIMS) Brief Interview for Mental Status score of 11, moderately impaired cognition, required limited staff assistance with eating, extensive assistance with all other (ADLs) Activities of Daily Living, and was always continent of bowel. The 6/9/14 quarterly MDS indicated the same. The significant change MDS, dated 3/17/14, indicated the resident had short/long term memory problems and moderately impaired decision making skill. The MDS indicated the resident required limited staff assistance with eating and extensive assistance with all other ADLs. The MDS indicated the resident was frequently incontinent of bowel and had no							

` '		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/	/22/2014
NAME OF PR	OVIDER OR SUPPLIER OME, INC			ESS, CITY, STATE Rane St N, KS 67654			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	9 Continued From page 23 constipation.			F 329			
	summary for bowel/b frequently incontinent	are Area Assessment ladder indicated the res t of bladder/bowel and esistance of 2 staff with	sident				
	The 9/2/14 care plan directed the staff to administer medications as scheduled, monitor the resident's response to medications, document the frequency and character of bowel movements and offer non-pharmacological bowel stimulants such as warm water drinks upon rising, and fruit juice. The care plan lacked time frames to direct the staff when to provide bowel stimulants or interventions.						
	The 7/3/14 physician's orders directed the staff to administer Colace (mild laxative) 100 (mg) milligrams, twice daily, (initiated on 1/22/14), (MOM) Milk of Magnesia (laxative), 30 (cc) cubic centimeters, as needed, daily, (initiated on 6/17/09), and Miralax (laxative), 17 grams, as needed, daily, (initiated on 1/5/10).		, cubic				
	Review of the resider reports revealed: No (BM) Bowel Move consecutive days) No BM 9/3-9/14 (12 of No BM 10/3-10/7 (5 of	consecutive days)					
	Review of the nurse's notes 8/1/14 through 10/15/14 revealed no nursing assessment of the resident 's bowel sounds or documentation of administration of interventions for the lack of bowel movements and no documentation the resident refused any bowel interventions to		of f				

	PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175506		B. WING		10/22/2014	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STAT	FE, ZIP CODE	•	
ANDBE HOME, INC			RANE ST I, KS 67654	1		
PREFIX (EACH DEFICIENCY MUST BE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 329 Continued From page 24 prevent or ease constipated. The 9/4/14 and 10/9/14 previews of the resident's indicated no recommendate bowel elimination managed. On 10/15/14 at 7:33 AM, resident in a recliner in his consider the assist to to the total to the total to the total	charmacist consultar medication regimen lations regarding the gement. Nurse Aide N stated is/her room. Nurse Aide N stated sistance of 2 staff will cumented the reside ord. He/she stated in the electronic recorn with the charting to f documented the stated in the electronic chart and the elect	ed the d the th ent's d and ent ys. he en es if O anted the o n ,	F 329			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	iK.	A. BOILDING		COMPLETI	
		175506		B. WING		10/2	2/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
ANDBE H	OME, INC			CRANE ST N, KS 6765	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	Continued From page	e 25		F 329			
F 371 SS=E	stated the resident wa able to let staff know in He/She stated the fact monitoring policy. Add the staff had not docu interventions for the 3 elimination document BM for greater than 5 care plan and the rou time frames to direct to bowel stimulants or in The facility failed to melimination in order to determine needed interase constipation. 483.35(i) FOOD PRO STORE/PREPARE/SI The facility must - (1) Procure food from considered satisfacto authorities; and	nonitor Resident #7's be prompt assessment to erventions to prevent o ocure, ERVE - SANITARY sources approved or ry by Federal, State or	ad ed. vel vified el owel ny the acked de	F 371			
	The facility had a cen sample included 14 re observation, record re facility failed to provid system of an ice mac under sanitary conditi	not met as evidenced be sus of 64 residents. The esidents. Based on eview and interview the le an air gap in the drail hine and prepare foods ions for the 64 residents lity and receive food an	e nage s				

		(X1) PROVIDER/SUPPLIER/C				' '	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILDING	i	COMPLETE	D	
		175506 B. WING 10/22/20		/2014				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ANDBE H	OME, INC			CRANE ST N, KS 6765	4			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 371	Continued From page	e 26		F 371				
	fluids from the kitcher							
	Findings included:							
	- On 10/13/14 at 9:40) AM, observation revea	aled					
	the ice machine drain	age system emptied di	rectly					
		no air gap or anti-backt	flow					
	valve to prevent back	flow contamination.						
	On 10/13/14 at 9:40 A	AM, Maintenance Staff	A					
	verified the ice machin							
	anti-back flow valve in the drainage system to		О					
	prevent backflow con	tamination.						
		AM, observation during nspection, revealed the						
	1) 2 air vents, above to with fuzzy, gray lint are	the food preparation are						
	vents	the food proparation or						
		the food preparation ar nd dust on the fan blade						
		fuzzy, gray lint and dus						
	hanging from the fan							
		hole in the block wall ι	ınder					
	the food preparation s 5) 4 light fixtures with	dust and lint on the ou	tside					
	covers							
		AM, Dietary Staff P veri	fied					
		d light fixtures needed f P also verified the kito	hen					
		d no documentation the						
	•	cleaned after 05/07/14.	-					
		Cook Weekly Cleaning						
		e staff to clean the circu	- 1					
		tinued review of the cle documentation to direc						
	staff to clean air vents		J. UIC					
		. 5						

	OF DEFICIENCIES F CORRECTION	. ,	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2	22/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	I	
ANDBE H				CRANE ST ON, KS 6765	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From page	e 27		F 371			
	The facility's 03/24/2000 Dietary Department Sanitation/Infection Control Procedure directed the staff to routinely clean non-food surfaces and fans to ensure a clean and sanitary environment. The facility failed provide an air gap in the drainage system of an ice machine and prepare foods under sanitary conditions for the 64 residents, who reside in the facility.						
			are				
	28 483.60(c) DRUG REGIMEN REVIEW, REPORT =D IRREGULAR, ACT ON		F 428				
	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.						
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.						
	The facility had a cen sample included 14 re reviewed for unneces interview, record revie pharmacy consultant drug irregularities to the director of nursing residents, in regards to	to adequately monitoring tessure and Resident #	e e on port or				
	Findings included:						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	:R:	A. BUILDING		COMPLET	ED	
		175506		B. WING		10/2	2/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ANDBE H	OME, INC			CRANE ST N, KS 6765	4			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 28		F 428				
F 420	- Resident #8's quart Set assessment, date resident scored 15 or for Mental Status, who cognition. The MDS in independent with most Living, ambulated with continent of bowel an indicated the resident antidepressant medic. The 4/30/14 (CAAs) Commany for psychotor indicate any instruction reporting of a resident The CAAs indicated the for falls as he/she had admission to the facility physician readjusted prevent further falls portion or the series of the design	erly (MDS) Minimum D ed 9/29/14, indicated the of the (BIMS) Brief Intervice in the (BIMS) Brief Intervice indicated the resident was (ADLs) Activities for It in a walker, and was debladder. The MDS is received 7 days of an action. Care Area Assessment ropic drug use did not one for the monitoring a tris elevated blood pression in the resident was a high defrequent falls prior to the resident's medication in indicated the staff were in the medications as orders and to assess and record in the resident's the resident's medications as orders and to assess and record in the resident's (SBP) systolic blood in the resident's blood in the resident's blood is and then report the ent's physician.	e view as Daily as Daily as Daily as Daily as Daily as Tons to an are to ered cord as Daily a	F 420				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2	22/2014
	ROVIDER OR SUPPLIER		201 W C	ESS, CITY, STAT RANE ST N, KS 67654			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	did not indicate the unit of the 4/22/14 physiciate to administer: 1) Coreg, (a high blooming) milligrams, twice 2) Cozaar (a high blooming) milligrams, twice 2) Cozaar (a high blooming) twice a day. The 5/1/14 physiciant to administer Norvast medication), 5 mg, do the 7/14/14 physiciate the resident had epison the 9/18/14 physiciate to increase Norvasc, medication), to 5 mg continues on the Conformation of the SBP to be repiphysician. The 9/23/14 at 8:28 the resident's blooding sitting 185/89, and so note stated Norvasc medication) was increased aday, due to the pressure. The resident's medicate resident's following the sident's following the sident	an's order instructed the sod pressure medication as a day. The progress resident's progress notes indicated the sodes of high blood pressure and the Cozaar. The resident's medical receiffic individualized upper orted to the resident's elevated by the resident's elevated by the resident's elevated by the resident's elevated by the resident's elevated the plood pressure notification of the resident's elevated the plood pressure notification of the resident's elevated the plood pressure notification of the resident's elevated by the plood pressure notification of the resident's elevated by the plood pressure notification of the resident's elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the plood pressure notification of the resident is elevated by the	staff re cated ssure. e staff ent ord limits ated 79/84, rses's	F 428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2	22/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANDBE H	OME, INC		201 W C	RANE ST			
			NORTO	N, KS 6765	4		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX		ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION DATE
TAG	OK LSC IL	DENTIFTING INFORMATION)		TAG	DEFICIENCY)	-FROFRIATE	
F 428	Continued From pag	20.30		F 428			
1 420	10/8/14 at 7:25 AM 1			1 420			
	10/6/14 at 4:00 PM 1						
	10/5/14 at 1:05 PM 1						
	10/2/14 at 2:59 PM 1						
	10/2/14 at 7:08 AM 1						
	10/1/14 at 2:55 PM 1						
	10/1/14 at 9:47 AM 1	173/65					
	10/1/14 at 9:46 AM 1	187/90					
	9/29/14 at 3:16 PM 1	178/83					
	9/29/14 at 7:30 AM 1	186/76					
	9/26/14 at 10:53 AM						
	9/26/14 at 7:35 AM 1						
	9/25/14 at 2:59 PM 1	-					
	9/25/14 at 6:49 AM 1						
	9/24/14 at 7:57 AM 1						
	9/23/14 at 7:11 AM 1 9/21/14 at 7:17 AM 1						
	9/17/14 at 7:17 AW 1						
	9/16/14 at 9:45 AM 1						
	9/16/14 at 7:00 AM 2						
	9/14/14 at 3:52 PM 1						
	9/12/14 at 7:28 AM 1	189/89					
	9/11/13 at 6:50 AM 2	200/80					
	9/9/14 at 7:03 AM 17	76/88					
	9/8/14 at 6:38 AM 18	31/85					
	9/7/14 at 7:26 AM 17						
	9/6/14 at 7:40 AM 17						
	9/5/14 at 9:07 AM 17						
	9/4/14 at 4:07 PM 19						
	9/3/14- at 7:05 AM 18						
	9/2/14- at 7:17 AM 1	83/83					
	Further review of the	resident's medical reco	ord				
		ow up documentation af	-				
		ated blood pressures, o					
		hysician notification of the					
	resident's elevated b						
		•					
	Review of the pharm	acist consultant review	on				
	6/5/14, 7/10/14, 8/7/	14, 9/4/14, 10/8/14 reve	aled				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
	175506		B. WING		10/2	2/2014	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANDBE HOME, INC			CRANE ST ON, KS 6765	4			
PRÉFIX (EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
the well groomed re his/her room, readin On 10/16/14 at 7:25 nurses or the medic blood pressures. On 10/16/14 at 8:45 nurses take the resident of 90-170/40-95 per verified the resident outside of the standired in the vital sign of 10/16/14 at 9:00 stated the nurses ar physician, blood preparameters or speciphysician, and staff physicians notification stated the nurses us blood pressure in the administering the remedications and the resident's blood prewas elevated and do resident's nurse's not verified the resident pressures with no do pressure being rependification. Administer pharmacy consultant addressed the elevated.	AM, Nurse Aide D state ation aides take the resident's blood pressures standing orders. Nurse had several blood pressures outside standing fic parameters set by his were to document the on. Administrative Nurse audit take the resident's blood pressure parameters set by his were to document the on. Administrative Nurse audit take the resident's blood pressure soutside standing fic parameters set by his were to document the on. Administrative Nurse audity take the resident's emorning before sident's blood pressure and in 15 minute ocument the reading in the ocument the physician trative Nurse F stated the thad not identified or outed blood pressures outs rameters with the directors.	er, in d. d the dent's eters E sures ed in se F nt's order s/her F the es if it he se F cood d e side	F 428				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/22/2014	
NAME OF PR	OVIDER OR SUPPLIER OME, INC		201 W C	ESS, CITY, STA RANE ST N, KS 67654			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 428	he/she expected the the resident's blood phe/she stated it was morbidity (the incider (the state of being su in the nursing homes. The facility's pharmadury irregularities to the director of nursing elevated blood press multiple blood press multiple blood press multiple blood pressure. Resident #7's quart Set assessment, date Brief Interview for Memoderately impaired staff assistance with with all other (ADLs) was always continent. The 6/9/14 quarterly. The significant changindicated the resident memory problems and decision making skill. resident required limiteating and extensive ADLs. The MDS indicated.	AM, Physician G state nurses to notify him/her pressures were elevated difficult to change the note of disease) or mortal bject to death) of resided, but blood pressure. By consultant failed to rethe resident's physician g, regarding Resident # ure, while he/she receivance medications. Sterly (MDS) Minimum Deat 9/2/14, indicated a (Eartal Status score of 11, cognition, required limit eating, extensive assist Activities of Daily Living to f bowel. MDS indicated the same and the MDS, dated 3/17/14,	eport or e8's yed ata BIMS) ted tance g, and e.	F 428			
	The 3/17/14 (CAA) C	are Area Assessment					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		1, ,	E CONSTRUCTION	(X3) DATE SI COMPLE		
		175506		B. WING		10/	22/2014	
	OVIDER OR SUPPLIER		201 W C	RESS, CITY, STATE RANE ST. N, KS 67654				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	summary for bowel/b frequently incontinen required extensive as toileting needs. The 9/2/14 care plan administer medicatio resident's response t frequency and charar and offer non-pharms such as warm water juice. The care plan I the staff when to provinterventions. The 7/3/14 physician administer Colace (milligrams, twice dail (MOM) Milk of Magne centimeters, as need 6/17/09), and Miralax needed, daily, (initiat Review of the resident reports revealed: No (BM) Bowel Move consecutive days) No BM 9/3-9/14 (12 of No BM 10/3-10/7 (5 of Review of the nurse's 10/15/14 revealed no resident 's bowel so administration of inter bowel movements ar resident refused any prevent or ease consecutive of the 9/4/14 and 10/9/	bladder indicated the rest to of bladder/bowel and assistance of 2 staff with directed the staff to as as scheduled, monit to medications, docume cter of bowel movemen acological bowel stimuladrinks upon rising, and lacked time frames to divide bowel stimulants of the schild laxative) 100 (mg) y, (initiated on 1/22/14) esia (laxative), 30 (cc) of the daily, (initiated on a (laxative), 17 grams, and aled on 1/5/10). Int's bowel elimination ement 8/9-8/14 (6) consecutive days) as notes 8/1/14 through on nursing assessment or unds or documentation erventions for the lack of and no documentation to bowel interventions to	or the ont the ts ants fruit irect r taff to solve the taff to the taff taff taff the taff taff taff taff taff taff taff taf	F 428				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			BUILDING		(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/	22/2014	
NAME OF PR	OVIDER OR SUPPLIER OME, INC		201 W C	RESS, CITY, STATE RANE ST N, KS 67654				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	indicated no recomm bowel elimination ma	nendations regarding the anagement. AM, observation reveale		F 428				
	On 10/16/14 at 7:55 AM, Nurse Aide N stated the resident required the assistance of 2 staff with toileting, and the staff documented the resident's BM on the electronic record. He/she stated nurses track the BMs via the electronic record and the aides cannot view the charting to determine when the staff documented the resident's last BM.							
	aides document BMs the electronic record message if no BMs at The nurse looks at the resident, if possible, offer a laxative, as no nurse assessed the at the resident was cogstated, at times Resiof residents without a stated he/she asked a (PRN) as needed by resident refused. He/document bowel sou interventions and ver documentation of both	AM, Nurse O stated the sin the electronic chart sends the nurse a residere documented for 3 date BM record and asks if they had a BM and the eded. He/she stated thresident 's bowel sound initively impaired. Nurse dent #7 had been on the BM for 3 days and Nuthe resident if he/she waxative, but sometimes /she stated nurses are tonds and PRN medication rified the record had no wel sound assessments interventions, or indication any interventions.	and dent ays. the en le ds if O e list rse O ranted the o on					
	stated the resident w	AM, Administrative Nura vas alert and oriented ar if he/she was constipat	nd					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506		B. WING		10/2:	2/2014
NAME OF PR	OVIDER OR SUPPLIER OME, INC		201 W (RESS, CITY, STA CRANE ST N, KS 6765		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	monitoring policy. Ad the staff had not docu interventions for the 3 elimination document BM for greater than 5 care plan and the routime frames to direct bowel stimulants or in The facility's consultate report, to the Director bowel elimination into	cility did not have a bow lministrative Nurse F ve umented any PRN bowe 3 periods in which the b tation lacked report of a 5 days. He/she verified to the staff when to provide the staff when to provide the rof Nursing, the lack of erventions, as indicated r than 5 consecutive da	rified el nowel any the acked le	F 428			
	SPREAD, LINENS The facility must esta Infection Control Prografe, sanitary and co to help prevent the detransmission of diseases. (a) Infection Control In The facility must esta Program under which (1) Investigates, continuous the facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection (b) Preventing Spreases (1) When the Infection determines that a resistance in the facility;	Program ablish an Infection Control it - crols, and prevents infection cedures, such as isolation an individual resident; and d of incidents and corrections. d of Infection	rol ctions ion, and cctive	F 441			

			1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175506		B. WING		10/:	22/2014		
NAME OF PROVIDER OR SUPPLIER ANDBE HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 201 W CRANE ST NORTON, KS 67654						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 441	Continued From pag (2) The facility must p communicable disease from direct contact w direct contact will trai (3) The facility must n hands after each direct hand washing is indice professional practice (c) Linens Personnel must hand transport linens so as infection. This Requirement is The facility had a cer sample included 14 n interview, record revi	ons od, if eir which of by: ne	F 441						
	failed to ensure the staff allowed the disinfectant, used by housekeeping staff to clean the residents' rooms, remained wet on surfaces for a minimum of 10 minutes.								
	Findings included:								
	Housekeeping Staff I using, Betco pH7P U Germicidal Detergenthe resident's sink, or doors, and door know the disinfectant solution the toilet, under the stwo gray steel shelve counter, Housekeepe	10 AM, observation reversal cleaning a resident's rulltra One Step Disinfectant Deodorant, to disinfect utside of the toilet, walls be. Immediately after willion on the plumbing behaink, hall/towel bars and es above the (BR) bathmer Staff I dried these iterousekeeping Staff I state	oom ant stant s, ping hind I the room ms						

) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		175506		B. WING		10	/22/2014			
	ROVIDER OR SUPPLIER			ESS, CITY, STA	TE, ZIP CODE					
ANDBE H	OME, INC		201 W CRANE ST NORTON, KS 67654							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE			
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		and apper and the aces are they per ctant dry.	F 441						